Horizon BCBSNJ: NJ DIRECT15

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016 - 12/31/2016
Coverage for: All Coverage Types | **Plan Type:** PPO
New Jersey State Health Benefits Program

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.state.nj.us/treasury/pensions/health-benefits.shtml or by calling **1-609-292-7524.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100** person/**$250** family for out-of network services only.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network coinsurance limit **$400** person/ **$1,000** family; Active employee medical out-of-pocket limit **$5,480** person/**$10,960** family. Retiree medical out-of-pocket limit **$5,499** person/**$10,998** family. Out-of-network providers **$2,000** person/**$5,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.HorizonBlue.com/shbp or **call 1-800-414-SHBP (7427).**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a written referral to see a specialist.	You can see the in-network **specialist** you choose without permission for this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 & 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-609-292-7524 or visit us at www.state.nj.us/treasury/pensions/health-benefits.shtml.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-609-292-7524 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	30% coinsurance after deductible	———— none ————
	Specialist visit	$15 copay/visit	30% coinsurance after deductible	———— none ————
	Other practitioner office visit	$15 copay/visit	30% coinsurance after deductible	Chiropractic care is limited to 30 visits combined per calendar year. Out-of-network coverage for chiropractic and acupuncture services are limited to no more than $35 a visit for chiropractic and $60 a visit for acupuncture or 75% of the in network cost per visit, whichever is less.
	Preventive care/screening/ immunization	No Charge	Not Covered	One routine physical per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance after deductible	———— none ————
	Imaging (CT/PET scans, MRIs)	No Charge	30% coinsurance after deductible	Requires pre-approval

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available through your employer.	Generic drugs	See separate Prescription Drug Plan SBC		——— none ———
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	30% coinsurance after deductible	——— none ———
	Physician/surgeon fees	No Charge	30% coinsurance after deductible	——— none ———
If you need immediate medical attention	Emergency room services	$75 copay/visit	$75 copay/visit	$50 copay/visit for physician referrals or pediatric (under age 19) ER visits; and if admitted within 24 hours, the copayment is waived. Payment at the in-network level applies only to true Medical Emergencies & Accidental Injuries.
	Emergency medical transportation	10% coinsurance	30% coinsurance after deductible	Limited to local emergency transport to the nearest facility equipped to treat the emergency condition.
	Urgent care	$15 copay/visit	30% coinsurance after deductible	——— none ———
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	30% coinsurance after deductible	Requires pre-approval. There is a separate $200 deductible per inpatient stay for out-of-network facilities.
	Physician/surgeon fee	No Charge	30% coinsurance after deductible	Requires pre-approval.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay/visit	30% coinsurance after deductible	Some specialty outpatient services require pre-approval. Inpatient services require pre-approval. There is a separate $200 deductible per inpatient stay for out-of-network facilities.
	Mental/Behavioral health inpatient services	No Charge	30% coinsurance after deductible	
	Substance use disorder outpatient services	No Charge	30% coinsurance after deductible	
	Substance use disorder inpatient services	No Charge	30% coinsurance after deductible	
If you are pregnant	Prenatal and postnatal care	$15 copay/visit	30% coinsurance after deductible	Copayment applies to initial visit only.
	Delivery and all inpatient services	No Charge	30% coinsurance after deductible	Requires pre-approval. There is a separate $200 deductible per inpatient stay for out-of-network facilities.
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance after deductible	Requires pre-approval.
	Rehabilitation services	$15 copay/visit	30% coinsurance after deductible	Requires pre-approval.
	Habilitative services	$15 copay/visit	30% coinsurance after deductible	Requires pre-approval.
	Skilled nursing care	No Charge	30% coinsurance after deductible	Requires pre-approval. Limited to 120 days in-network and 60 out-of-network facility days for a combined maximum of 120 days per calendar year. There is a separate $200 deductible per inpatient stay for out-of-network facilities.
	Durable medical equipment	10% coinsurance	30% coinsurance after deductible	Requires pre-approval for all rentals and some purchases.
	Hospice service	No Charge	30% coinsurance after deductible	Requires pre-approval. There is a separate $200 deductible per inpatient stay for out-of-network facilities.

If your child needs dental or eye care	Eye exam	$15 copay/visit	Not Covered	Limited to one exam every 12 months.
	Glasses	Not Covered	Not Covered	——— none ———
	Dental check-up	Not Covered	Not Covered	——— none ———

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing (inpatient)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (for pain management only)
- Bariatric surgery (requires pre-approval)
- Chiropractic care (limited to 30 visits/year)
- Hearing aids (Only covered for members age 15 or younger, maximums apply)
- Infertility treatment (requires pre-approval)
- Non-emergency care when traveling outside the U.S. (subject to deductible/coinsurance and balance billing.)
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium,** which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-414-SHBP (7427). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Horizon Blue Cross Blue Shield of New Jersey Member Services at 1-800-414-SHBP (7427). You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebda/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-609-292-7524.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,350
- **Patient pays** $190

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$170
Total	**$190**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,050
- **Patient pays** $4,350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$150
Coinsurance	$0
Limits or exclusions	$4,200
Total	**$4,350**

Please note that some of the Limits or Exclusions listed above may be covered under the Prescription Plan.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.